Leprosy Training Centers

Report of Assessment - 1987.

DR R. GANAPATI

02801

L E P R O S Y T R A I N I N G C E N T E R S

R E P O R T O F A S S E S S M E N T - 1 9 8 7

DR R GANAPATI

WHO CONSULTANT

Dr R Ganapati

: Director
Bombay Leprosy Project
6/27 Amar Bhuvan
Sion (East)
BOMBAY 400 022

Tel: 47 40 66

C O N T E N T S

..2

ACKNOWLEDGEMENT

The most crucial factor determining the successful outcome of antileprosy operations in the country is related to raising manpower though training of high standard. The dynamism noticeable in the Leprosy Division of the Directorte General of the Health Services New Delhi leaves one with no doubt that the task of improving the training calibre will most certainly be achieved within as short a time as possible.

It has been my great pleasure and privilege to have been assigned this important task by the Government of India.

I thank Dr CK Rao, Dy Director General of Health Services (Leprosy), most sincerely for asking me to do this job and for the constant encouragement given to me throughout the period of extensive tours which the assignment necessitated. I am thankful to the World Health Organization for the financial support provided.

I am indebted to Dr NS Dharmashaktu Dy Asst. Director General Health Services (Leprosy), for offering most useful suggestions and assistance in various ways besides companionship during some part of the tours.

The state programme chiefs and officers and staff of Leprosy Training Centres were most helpful and hospitable during our visits in connection with the assessment and I extend my gratitude to them.

It is hoped that this assessment will enable us to approach the task of eradication of leprosy more meaningfully.

13 March 1987

DR R GANAPATI

ABBREVIATIONS USED

1.	CLTRI	:	Central Leprosy Teaching and Research Institute
2.	DGHS	:	Director General of Health Services
3.	DLO	:	District Leprosy Officer
4.	LCU	:	Leprosy Control Unit
5.	LT	:	Laboratory Technician
6.	LTC	:	Leprosy Training Centre
7.	MDT	:	Multi-drug Therapy
8.	MO	:	Medical Officer
9.	MPW	:	Multi-purpose Worker
10.	NLEP	:	National Leprosy Eradication Programme
11.	NMS	:	Non-medical Supervisor
12.	PMW	:	Para-medical Worker
13.	PT	:	Physiotherapy Technician
14.	Rec Surg	:	Reconstructive Surgery
15.	SLRTC	:	Schieffelin Leprosy Research & Training Centre
16.	Shoe Tech	:	Shoe Technician
17.	SLO	:	State Leprosy Officer
18.	THW	:	Temporary Hospitalisation Ward
19.	ULC	:	Urban Leprosy Control
20.	ZLO	:	Zonal Leprosy Officer

REPORT ON ASSESSMENT OF LEPROSY TRAINING CENTRES

29 October 1986 to 11 February 1987.

INTRODUCTION

The edifice of National Leprosy Eradication Programme (NLEP) requires to be manned by staff equipped with reasonable technical knowledge which will enable them to understand intricacies involved in the two most important facets of leprosy work:

1. The difficult and responsible job of overcoming mycobacterial population through proper administration of chemotherapy at the field level without endangering the society to the risk of exposure to drug resistant form of bacilli and

2. Carry measures to prevent deformities, the most dreaded morbid sequelae of the disease, to the deformity prone subjects in the field situation and see that they adopt these measures regularly.

Besides the above two major tasks, there are several other responsibilities for which knowledge and skill have to be imparted to the staff.

To raise the enormous manpower needed to undertake these objectives of NLEP commensurate with the gigantic nature of the leprosy problem, vital centres known as Leprosy Training Centres (LTC) where such knowledge can be acquired have been created, 45 of which are scattered all over the country and are functioning through the control of government (central and state) as well voluntary agencies (international and national).

ORIGIN OF LTC

When National Leprosy Control Programme came into existance in 1985, the technical knowledge required for field operations of leprosy control was deemed so simple as to impart some simple

...2/-

instructions to candidates who had educational qualification up to matric and put them on the job as paramedical workers(PMWs) The importance of traini g them systematically in an extensive manner was realised at a later stage. In the beginning such centres were located in close relation to big leprosy hospitals some of which were really created as isolation homes for leprosy patients in those years. The LTCs situated in hospitals such as Noornad, Brambe, Chengalpattu, Akrampalli, Gowripur etc are classical examples to show that the planners were keen to have access to the abundant clinical material available in such hospitals for teaching purpose. One can also notice the tendency over the years to locate training centres in bigger urban locations e.g. newer building coming up exclusively for training activities in Cuttack, Hyderabad and Calcutta as leprosy hospitals were earlier situated mainly in rural areas and probably it was realised that the facilities available in the urban areas were also required for imparting more sophisticated training in leprosy to keep pace with the newer advances in the subject.

THE NLEP

It is important to have a background knowledge of the objectives and working pattern of NLEP if trained force ideally equipped to carry out these tall objectives to perfection is to be planned. An extract from a recent publication of Leprosy Division of Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi provides exhaustive information is therefore quoted verbatim.

Even though there were widespread antileprosy activities in the country prior to 1985, these were neither planned nor organised, being run by desperate voluntary and religious groups. The first organised governmental effort for leprosy control was made in 1955 by Government of India in the form of National Leprosy Control Programme (NLCP). It started with the primary objective of controlling leprosy through mass domicilliary treatment with sulphones. To begin with, it was a Centrally-Aided Scheme with thurst on the rural areas of high and moderate endemicity.

...3/-

For low endemic states, the expectation was to provide anti-leprosy services through the existing infrastructural facilities meant for general health services. The Centrally Aided Scheme was converted into a Centrally-Sponsored Programme in 1969-70, providing for total expenditure of this account to be borne by the Government of India.

In 1983, following the recomendations of a working Group appointed under the Chairmanship of Dr. M. S. Swaminathan, the then Member, Planning Commission, it was considered that a stage had arrived for undertaking an eradication programmed for leprosy in the next 20 years, taking advantage of the twin developments of great advances in the chemotherapy of leprosyand the extended reach of mass media. Consequently, the programme was redesignated from one of controlling leprosy to that of its eradication.

a. Strategy.

It is based on the strategy of controlling the disease through reduction in the quantum of infection in the population, reduction in infective sources, thus breaking the chain of disease transmission. The programme is built on the following basic activities.

(i) .Survey and case detection;
(ii) registration of cases for treatment
(iii) provision of continuous treatment with dapsone to all cases, as close to their homes as possible;
(iv) introduction of multi-drug therapy (MDT) with rifampcin, clofazimine and dapsone, in a phased manner to cover all endemic areas by 1985;
(v) education of patients, their families and community at large about leprosy; and
(vi) correction of deformities.

b. Infrastructure

NLEP is a vertical programme with its own infrastructure and training facilities. However, in areas with endemicity of

less than 5 per 1000 population, leprosy services are provided by the general health services through the Primary Health Centres (PHC). A five-tier organizational structure has been created over the years for NLEP. The apex body is National Leprosy Eradication Commission, which oversees the Leprosy Eradication Board responsible for implementing the plans and policies as laid down by the Commission. An officer of the rank of a Deputy Director General of Health Services acts as the Director of the Programme.

In the States, and Additional/Joint/Deputy Director Health Services acts as the State Leprosy Officer for planning, programming and implementation of the NLEP.

At the district level, the District Medical Officer of Health looks after leprosy work in his district in addition to his other duties in low endemic areas. District Leprosy Officers (DLO) or Zonal Leprosy Officers (ZLO) have been made available at the rate of one officer per district where leprosy is highly endemic and one for 2 or 3 district where it is of moderate endemicity.

Leprosy services fan out from two types of units that operate at the periphery (i) Leprosy Control Units (LCU) and (ii) Urban Leprosy Centres (ULC) situated in the rural and urban areas respectively. There is one LCU for every 4-5 lakh population and for 30 to 70 thousand population.

A LCU is manned by a Medical Officer (MO) supported by four Non-medical Supervisors (NMS) and 20 Paramedical workers (PMW) and other ancillary staff.

The ULC is looked after by a NMS functioning under the supervision of a MO in charge of a dispensary or hospital to which the ULC is attached.

...5/-

Another type of Centre called Survey, Education and Treatment Centre exists to serve a population of about 25,000 each in areas with endemicity of less than 5 per 1000 population. It is attached to a PHC or a dispensary or hospital located in t the area. One PMW or a Non-medical Assistant (NMA) is given to each SET Centre and works under the guidance of Medical Officer in charge of PHC.

In addition, Temporary Hospitalization Wards (THWs) have been provided to serve those in need of special care. A limited number of institutions have been developed with facilities for reconstructive surgery.

Separate institutions cater to the need of trained manpower required for the programme. Besides organising courses for the training of PMWs, NMSs, Laboratory Technicians and Physiotherapists, these institutions also prepare tailormade orientation courses to answer special needs of the programme, such as developement of manpower for MDT. A summary of existing infrastructure is given below:

TABLE - 1

Existing infrastructure under NLEP	1985
Leprosy Control Units	403
Urban Leprosy Centres	661
Survey, Education and Treatment Centres	9686
Temporary Hospitalizationsx Wards	253
Reconstructive Surgery Units	75
District Leprosy Units	190
Leprosy Training Centres	43
Sample Survey and Assessment Units	17

...6/-

Besides the creation of infrastructural facilities as part of NLEP, interested Voluntary Organizations have been brought under the fold of NLEP through provision of grants to meet the recurring and non-recurring expenses e.g. purchase of equipment and vehicles.

e. Services for Eradication of Leprosy

Important service engisaged for containment of infection in the community includes

(i) Case detection

Early detection of case is emphasized for better results of treatment and early cure as well as for prevention of physical deformities. Health education campaigns are organized to promote voluntary reporting. Population surveys are carried out by PMWs and NMSs

(ii) Treatment delivery

Treatment, under the programme, is delivered through clinics held at fixed road side points for every 5 to 10 villages. Such clinics are also held in general hospitals under dermatology or in general hospital medical outdoor and in health centres.

(iii) Case taking

As new patients come for diagnosis and treatment, their clinical condition is noted in case cards and their infectivity status confirmed by bacteriological examination to determine the nature of disease and the treatment required.

(iv) Drug regimen

It is expected that the prescribed drug regimen shall be followed for the treatment of paucibacillary and multibacillary cases both in respect of dapsone monotherapy

...7/-

as well as MDT. Guidelines on case detection, follow-up and discharge have been printed and provided in a booklet form to all health workers under NLEP.

(v) Recording and reporting of data

A system of recording and reporting has been developed for the programme, Clinical records of individual cases and epidemiological records of individual villages are maintained and reported ~~xxx~~ on a monthly and quarterly basis and analysed once in a year. Officers at different levels are responsible for timely submission of reports, their analysis and the necessary follow-up actions.

(vi) Health education

Information related to leprosy -- its causation, mode of transmission, curability, need for regular treatment in the prevention of deformities and dispelling erroneous beliefs, is expected to be promoted by all workers under the NLEP, during the course of their other activities. The targets groups are the patients, their family members and the community at large.

(vii) Public participation in NLEP

It is expected that sustained health education activities will lead to a change in the attitude and beliefs of the people and promote community participation in early detection of cases, prevention of deformities, social acceptance and rehabilitation. All programme personnel at their levels are responsible for promoting such public participation.

OBJECTIVES OF ASSESSMENT

To cope up with the responsibility of carrying out the gigantic work of NLEP, detailed above, necessary manpower has indeed to be continuously raised and replenished. Hence the training component becomes the most vital component of programme. The

...8/-

need for reappraisal of the functioning of LTCs was therefore felt essential in the light of the newer technology now introduced in the forms of multidrug therapy (MDT) and in the context of redesignating programme from NLCP to NLEP in the year 1983. The specific terms of references of the assessment of LTCs were as follows:-

1. To assess the existing facilities vis-a-vis the training objectives.

2. To review the ongoing training programme to identify the weaknoss and strong points.

3. To review the utilisation of training facilities vis-a-vis the requirements of these centres.

4. To assess the utilisation of educational material including audio-visual equipments supplied by various agencies to improve the methods of teaching.

5. To ascertain the activities of the Centres during the period when no training programme are going on.

INFRASTRUCTURE FOR TRAINING

The map shows the location of 45 training centres established over the years, and it can be seen that the LTCs are mainly located around endemic zones.

M A P

...9/-

The following table shows the statewise distributions of the Centre

TABLE 2

Sr No.	State	No. of L.T.Cs		
1.	Andhra Pradesh(AP) & Tamil Nadu (TN)	7 each	....	14
2.	Maharashtra	6 Nos.	....	6
3.	Karnataka, Utter Pradesh (UP) and West Bengal (WB)	5 each	....	15
4.	Bihar	3 Nos.	....	3
5.	Madhya Pradesh (MP) and Orissa	2 each	....	4
6.	Assam, Kerala and Gujrat	1 each	....	3
	TOTAL			45

There are a total of 45 LTCs recognised by the Central Govt. In addition, two centres viz the State Govt. centre at Rewa (M.P.) and Gremaltes Madras (TN) are also offering trainings Those are not recognised.

The training capacity of these centres (excluding those not yet recognised by the Central Govt.) is reported to be as follows:-

TABLE - 3

Category	No. of training centres	Annual training Capacity	No. trained till 1984
Paramedical Workers	39	2,048	9,710
Nonmedical Supervisors	6	91	669
Lab. Technicians	7	120	1,136
Physiotherapy Technicians	5	61	273
Health Educators	2	20	329
Medical Officers	9	234	1,415

...10/-

METHODS OF ASSESSMENT

The following centres were selected to be visited as per a tour schedule drawn in consultation with the Deputy Director General of Health Services (Leprosy) Delhi.

UP	: 1) Dehradun 2) Barabanki 3) Varanasi
WB	: 4) Calcutta school of Tropical Medicine 5) Grecaltes training centre in Calcutta* (German Leprosy Relief Association - GLRA) 6) Purulia* (The Leprosy Mission) - TLM)
Bihar	: 7) Dhanbad* (GLRA) 8) Brambe 9) Sehore
Orissa	: 10) Berhampur
Maharashtra	: 11) Nanded 12) Solapur 13) Pune 14) Nagpur
AP	: 15) Tirupati 16) Hyderabad 17) Rajahmundry
Karnataka	: 18) Gulbarga 19) Raichur 20) Bangalore
TN	: 21) Tirukoilur 22) Chengalpattu** 23) Chetpattu* 24) "Gremaltes" Training Centre in Madras* (GLRA) (GLRA) (not recognised)

All the above centres were visited as per schedule without a single exception. The following centres not scheduled in the above list were also visited as these were situated somewhat in proximity to the above.

WB	: 1) Howarah 2) Bankura 3) Gowripur** (RLTRI)

---

*Voluntary organization **Central Govt. Institutions.

...11/-

Orissa	:	4) Aska ** (RLTRI)
AP	:	5) Salur
TN	:	6) Pollambakam

The cities where the office of the leprosy programme officer for the State or the Directorate of the Health Services are situated such as Lucknow (WB) Bhopal (MP), Bhubaneswar (Orissa) Bombay (Maharashtra) were also included in the tour to facilitate discussions with the concerned officials.

In all there was an opportunity to visit 30 out of 47 LTCs over a period of three months.

It must be noted that the following centres were not visited during this assessment and any reference to such centre is from information gathered from authentic sources.

UP	:	1) Central Jalma Institute, Agra ** 2) Naini* (TLM)
Bihar	:	3) Mairwa
MP	:	4) Raipur **(RLTRI) 5) Rewa (not recognised)
Maharashtra	:	6) Jalgaon 7) Miraj *(TLM) 8) Wardha *(Gandhi Memorial Leprosy Foundation) GMLF)
AP	:	9) Pogiri 10) Warangal 11) Chickalpalli * (GMLF)
Karnataka	:	12) Hubli (Govt.) 13) Hubli (Swiss Emmaus)
TN	:	14) Karigiri * (Schefflien Leprosy Research & Training Centre-SLRTC)

Gujarat	:	15) Baroda
Kerala	:	16) Nooranadu
Assam	:	17) Boko

A questionaire (Appendix 1) was sent in advance to all the state Programme Officers and Senior Officers in-charge of LTCs and clarifications on all the points was made through personal interview with the senior medical officers incharge of the LTCs as well as all the available technical staff. The student trainees were examined whereever these were available both individually and collectively. Infrastructural facilities available with the centres such as, lectures hall, faculty room, library, audio-visual equipments and hostel etc were personally inspected. The strengths and shortcomings in respect of each centre were not only noted carefully but the views of the senior staff especially MOs, Sr. NMSs as well as the student traineers were also recorded. The technique of examination of candidates was observed wherever possible.

OBSERVATIONS AND RECOMMENDATIONS *

BACKGROUND

The highlights of the observations explained later in detail have to be viewed in the broad background of the performance of some of the key states in the matter of filling up the sanctioned posts and the percentage of trained staff among those in position, as shown in the following two tables.

...13/-

* These are based on data provided by the office of the DGHS and not all of them are necessarily updated.

Table 4

Percentage of vacancies in some key states

	.Maharash-tra	Andhra Pr-adesh	Karnataka.	Bihar	.West Bengal
M. O. s	0.7	40.1	25.8	26.3	26.3
N.M.S.s	12.6	9.9	28.2	18.8	8.6
P.M.Ws	4.4.	13.6	31.4	4.3	7.4
Lab. Techs.	13.9	14.9	68.3	70.6	31.0

Table 5

Percentage of trained staff in some key states

	.Maharash-tra	.Andhra Pr-adesh	.Karnataka.	Bihar	. West Bengal
M. O.s	66	100	22	11	92
N.M.S.s	100	100	61	6	68
P.M.W.s	100	100	88	91	59
Lab. Techs.	86	100	100	100	55

The wide disparity in performance between states is obvious at a glance at the above figures, conditions in states like Maharashtra and AP on one hand standing out in striking contrast to Karnataka, Bihar and WB.

The figures by no means reflect the correct position as of today as number of new post have since been sanctioned (e.g.-114 in MP more than 340 in TN). While some states (eg TN, MP) reportedly appoint staff especially PMWs only after training, in some others (eg WB) Bihar) posts are filled up with untrained candidates with some hopes of getting them trained while they are in service. Often such candidates continue to serve for very long periods without formal training.

The fact that the national scene at present as far as training status of the manpower carrying out the task throughout the length and breadth of this country is by no means uniform should be emphatatically stressed. Excellence in performance in some part of the country in the face of substandard levels prevailing in regions elsewhere is a paradox which deserves immediate remedial measures.

GENERAL PERFORMANCE

One of the most important observations of the study is that state government-manned LTCs are not functioning effectively as the expertise of the staff and infrastructural facilities are not utilised fully for raising the manpower meant for to be employed by the Government as well as various Voluntary agencies towards the NLEP.

It is disheartening to see that even within the ambit of the NLEP the already available staff expertise and facilities in one part of the country are not harnessed for recruting staff so badly needed in some other part of the country. Administrative and bureaucratic procedures to be overcome in this respect have to be very seriously considered.

.By and large voluntary agencies which manage extremely limited number of LTCs at present, particularly those supported by international organizations seem to have fared far better in offering high quality training of PMWs, in addition to big research cum training centres like Jalma Institute at Agra and CLRRI at Chengalpattu as far as MOs and NMSs are concerned. The regional centres like RLTRI at Aska, Gowripur and Raipur have been started with good intention but still they have yet to fullfill their roles effectively. Inspite of the fact some of them have been functioning for considerable number of years they are not still working in full swing. It is recommended that such of those large centres which are functioning well throughout the country as well as upgraded RLTRIs should be given the responsibility of improving the quality of training in several smaller LTCs nearby in their respective areas in a regional manner

...15/-

so that they should also be responsible for improving the calibre of teaching in such smaller centres by making use of their experienced and qualified staff.

RECRUITMENT

Standards of selection should be uniform. Bureaucracy in the face of enormity of applications for jobs (e.g. TN, UP) seems to have delayed recruitment and thereby influenced the functioning of LTCs. In some states, officials are even apprehensive of advertising for the sanctioned posts, as the administrative machinery will not be able to cope up with the flood of applications from a host of unemployed youth seeking one of the most lucrative jobs today namely that of a paramedical worker.

Some states (e.g. AP) have filled all the vacancies with trained staff and reached a "saturation point" leading to LTCs being overstaffed. However PMWs from such states manage to get sponsorship recommended from unauthorised institutions to obtain seats for training in some other states, as at present the job of PMW is much sought after. This is a dangerous trend and admission to training centres should be strictly monitored by State Programme Officers and unless SLOs recommend specifically, candidates should not be taken up for training. Some voluntary organizations offering training should make a particular note of this. This in other words calls for greater coordination between voluntary organizations engaged in training and the govt. sector in the larger interest of meeting the manpower needs of the country as a whole.

STAFF CATEGORIES*

a) Medical Officers

The training needs with reference to MOs can best be understood from the following appraisal of the Report of the Study Team

...16

---

*The most important category of PMWs is not included in this list as most of the remarks on training throughout the text of this report pertain to this category unless referred to otherwise.

on Leprosy, Maharashtra State ("Gavai Committee") published in 1982 (p.24), keeping in view that the performance of this state is generally recognised to be relatively better compared to other states.

"The experience in respect of Medical Officers of Leprosy Control Units over the years is utterly dismal. Barring a few exceptions, Medical Officers are most reluctant to be posted at Leprosy Control Units and those who are posted take least interest in the programme. They avoid undergoing training in leprosy and even those who are trained are disinterested in the Leprosy Work. The apathetic attitude of the medical officers has a definite demo ralising effect on the entire staff. Thus, the very purpose of establishing separate Leprosy Control Units has been defeated."

While in some other states, the situation is perhaps not as bad, the inference regarding the immediate need for strengthening this facet of NLEP can well be appreciated.

The sophistication of curative medicine today offers far greater promises for a medical graduate than the mundane duties of an officer in NLEP. In the course of this assessment it was pathe tic sometimes to encounter patients with type I and type II leprosy reactions occupying THWs manned by untrained MOs not conversant with the management of such cases with proper doses of steriods or clofazimine. It was learnt that the officers posted in THWs were more interested in their post graduate studies rather than learning how to treat leprosy patients. The recommendations of the expert bodies that the THWs should be brought under the administrative control of SLO/DLO to establish a link between the field and services has still not been implemented.

The training offered to MOs at least in some centres tends to be rather laboratory orientated with hardly any opportunity within the period of six weeks to arrange effective demonstration of field facets of the programme.

In the state of Maharashtra as high approportion as 44% of MOs are reported to be untrained. Though the rest of the categories of

...17/-

staff who are supposed to work administratively under the MOs are trained. In a large state like Bihar with a heavy leprosy problem hardly 7 trained officers appear to be available out of approximately 70 sanctioned posts. Moreover, it is common to see that trained officers are transferred or manage to get transferred leading to wastage of training imputs. In rare instances class I officers manage to retain the training posts in chosen cities, avoiding deputation for training. The situation can-not be helped unless a statewise reappraisal with special reference to this category of staff is carried out and drastic steps taken, regarding the basic training as well as refresher training course. Such reappraisal should not be done at the bureaucratic and administrative levels alone without the presence of acknowledged experts in the clinical and field aspects of leprosy.

b) Nonmedical Supervisors

As regards the NMS.., he occupies a key position in the NLEP as MOs are often untrained or are transeferred. 33% of NMSs out of 2361 in general are reported to be untrained. Accurate figures on how many posts of NMSs have been sanctioned more recently and how many are occupying positions currently without training in various states throughout the country are not available. If available this may reveal a serious lacuna in the programme. Many states follow a system of promoting a PMW as NMS without insisting on recognised training meant for this category. Only voluntary organizations (TLM and GMLF) and CLTRI besides the Poona State Govt. Centre offer training of significant quality for NMSs today. A few RLTRIs are said to be capable of taking up this responsibility. More centres should undertake re-orientation training as well as regular course for NMSs and within a specified time. The completion of this proce as involving ever mounting staff is needed indeed a challenging task and should however be aimed at.

c) Junior Laboratory Technicians (Smear technicians)

There is no aspect of NLEP which is more depressing than the laboratory services. This fact clearly emerged in the first workshop on a subject, of this kind held in Calcutta recently (February

...18/-

1987)

This has also been stressed in no uncertain terms by the "Independent Evaluation" teams appointed by the Govt. of India in 1986.

Prescribed qualifications for the person responsible for reporting on skin smears for AFB at present is a laboratory technicians course for one year. Still reliable skin smears reports are a rarity in many centres of NLEP. Slides examined at random indicated poor staining besides dust particles sticking to the smears. Such state of affairs can hardly be tolerated in centres attempting to teach candidates. Moreover in certain centres it was revealed that candidates show a hesitency in taking skin smears from leprosy patients owing to generally prevalent stigma. If trainers cannot overcome this with reference to any category of trainees under any situation, the training should be considered as incomplete or useless.

While technicians trained in general laboratory techniques for longer periods may be an advantage, under the standards currently prevailing, this should be considered as superflous and a luxury which the programme can hardly afford. Further such techiniciams are transferred or leave the service for establishing private practice leading to wastage of money and energy spent towards their training. In some states like WB 55% are reproted to be untrained.

Simple smear technicians course for three months could well be encouraged. Only GMLP, SLRTC Karigiri and Gremaltes (yet unrecognised) are offering this type of training at present. If more smear technicians are employed, the turnover of smear reporting could be improved as this is the weekest facet of NLEP. At the Calcutta workshop it was decided that such category of staff should be designated as "Junior Laboratory Technicians (smear)".

Among the centres visited, Gremaltes, Madras, Bombay Leprosy Project of GLRA and others situated in urban areas are most suitable for this purpose. It is strongly recommended that several such centres capable of undertaking the course should be immediately identified. Curriculum, syllabus and techniques of rorganising such courses are already available at the SLRTC Karigiri and the

...19/-

same should be adopted without losing time. As for the future prospects of such staff they may be promoted as Senior Laboratory technician after deputation for conventional training for one year.

The report of the Independent evaluation (1986) also has recommended recruitment of "Smear technicians" with three months training course.

d) Health Educators

Health Educators also form an important component of the scheme and there are very few trained health educators in the country, though some states (e.g. TN) seem to have greater number. More centres capable of offering training for health educators, particularly those showing a storng inclination to start such courses should be identified and such training started (eg. Gremaltes, Dhanbad) though efforts in this direction should not be at the cost of immediately meeting other training needs of the country.

e) Physiotherapy Technicians

The trend in the whole country emphasises today almost nothing except the process of breaking the chain of transmission through drug distribution employing PMWs and the operational problems directly related to chemotherapy. It is difficult under the circumstances to visualise building an ideal national set up which will meet the clinical requirments of patients needing physiotherapy though field teams consisting of trained physiotherapy technicians. There is only a handful of centres offering such training, those centres connected with TLM excelling in quality in this respect. Steps to strengthen existing centres and identify more such centres capable of offering training physiotherapy should be taken as early as possible.

It should be mentioned that technicians trained in some hospital based centres have found their academic skills acquired in preoperative and post-operative physiotherapy etc. not quite useful and relevant when placed in field situations. It is suggested that the

The curriculum should lay greater stress on field approaches to prevention of deformities.

Short course (two weeks) orientation training exclusively in elements of physiotherapy for PMWs is desirable. This could be done by deputing them to selected institutions. Alternatively a mobile team of physiotherapists can visit leprosy control programmes to orient the PMWs.

f) Statistitians

Statistians' course may also be a need for NLEP in the long run but does not seem to be the immediate necessity. The existing course offered in GMLF Wardha may be assessed and encouraged in this respect.

CURRICULUM

A drastic revision in the curriculum is necessary. Archaic aspect of the subject, not directly necessary for PMW's functioning in the field find a prominent place. Curriculum should pointedly aim at imparting knowledge on more field oriented aspects of leprosy control as it is practised to-day. It was noticed that in some centres manned particularly by untrained medical officers, the quality of teaching in relation to subjects like anatomy, physiology and pharmacology etc. was exceptionally good, mainly because, the officers themselves were not conversant with the operational strategies of NLEP and principles of chemotherapy etc and did not show inclination to teach these subjects.

The DGSH has taken a major stride recently in organising workshops dealing with most important ractical subjects such as (1) Reactions in Leprosy, (2) Criteria for Cure, Discharge, and Certification and (3) Laboratory Ser-vices. The booklets containing the proceedings and recommendations of these workshops should form the basis for intensive teaching. Trainers should be throughly

...21

conversent with the contents of these booklets which should be made available freely to the libraries of LTCs. The recommendations contained in these booklets represent consensus opinions arrived at after intensive deliberations by acknowledged experts and no departure from the facts found in these current publications should be permitted. Arbitrary and dogmatic statements based on personal experiences of the teacher with a few patients should not be made.

Besides teaching leprosy from purely a medical angle, it is desirable to impart some basic knowledge on public relations, communication skills behavioural sciences and management principles. While inviting experts on these specialities to give lectures, it should be ensured that these subjects are simplified to suit the audience.

DURATION OF COURSES

The courses should be restricted to two months for NMSs and four months for PMWs. There is no doubt that this will lead to increased turnover of manpower needed immediately throughout the country and benefit the programme provided of course, the content of teaching is made far more task oriented. At the recommendation of the DGHS workshop on "Training Programmes relevant to NLEP" held in Chengalpattu in July 1985, it is learnt that CLTRI, Chingalpattu and SLTRC Karigiri were asked to experiment on the feasibility of condensed courses for NMS and PMW training. While the results of such experiment are not yet officially available, it is learnt from the Director of SLRTC Karigiri that the four month course for PMWs is "probably adequate but there are administrative reasons why it cannot work unless it becomes an all India policy", as students of the batch under trial were "worried that their recognition would be prejudiced and they would not get promotion etc". It is therefore imperative that a firm decision is taken by the Govt. in this regard as early as possible.

...22

TEACHING TECHNIQUES:

Techniques commonly adopted are more in the form of dry lecture and the student memorises the notes dictated rather than learn and understand field aspects from a practical angle. The techniques adopted should be so demonstrative that the students understand their field task better. Large groups in the field become unmanageable. For practical demonstrations, it is imperative that the batch is divided into multiple small groups. Number of hours of posting for field teaching is also poor in most centres. Some Govt. centres in Maharashtra (eg. Nanded) have done well in this respect. Each training centre should be allotted its own specified field area for effective field teaching. Actual MDT administration in field set up should be practically demonstrated. MDT districts could be used for this purpose.

It is noticed that where training centres are located in medical colleges, the field oriented training is poor, as clinical dermatologists have still not realized the need for such a training. The teaching appears to be mostly clinical and not p blic health oriented at present. Department of Preventive and Social Medicine should also be involved in the programme.

MEDIUM OF TEACHING

One of the greatest hurdles in making students understand is the need to translate all available knowledge into the state language, as the standard of English among the students is very poor in most of the states. This makes it almost impossible to get the candidates trained in states other than their own. Discussions with the Directors of State Health Programmes reveal that acceptance of candidates from other states even in govt. centres which are idle is unimaginable at present. However, from an academic angle and to introduce an element of uniformity and equilibrium in the calibre of staff in the country dispersion of candidates would appear to be necessary. In rare instances certain students from alien states were also found in some stray centres

(e.g. students from AP in voluntary institutions like Dhanbad in Bihar). Teachers should learn the skill of teaching in English as well as the state languages.

EXAMINATION SYSTEM

Examinations are not conducted in such a manner as to be task oriented. Often in most centres examinations are highly theoretical aiming at judging the knowledge of an ordinary PMW, from high medical standards. Subjective type of examination system should be introduced as early as possible and multiple choice questions (e.g. Chetput) should be favoured.

Some states (e.g. TN).) conduct common examinations for govt. as well as voluntary organisations. This is a healthy trend and this under ideal circumstances should be encouraged in other states also, though practical difficulties in instituting such measures should be considered.

Questions could be derived from a large pool of multiple choice type (question banks) and used in all the states so that the knowledge imparted in various states would conform to common standards. During the course of the training, assessment should be made which could be used as a factor for guidance of teachers before students appear for the final examination. Some of the best systems of assessment of assimilation of material tought during the course of training were found in Purulia and Salur and are worthy of emulation.

EXAMINERS

Experienced examiners in leprosy should conduct examinations so as to maintain adequate field standards. It is preferable that examiners besides having experience in teaching leprosy, should as well have practical knowledge of operational approaches to leprosy control work in the field. It is regretable that some candidates receiving training especially in reputed medical college when tested by the assessment team during the examination were found not to have grasped the importance of significant facets of NLEP such as LCU, ULC, THW, RSU etc. and their working systems. This is possibly

..24

because examiners themselves did not feel the need for the candidates knowing about these aspects. At random testing during the course of examination also showed that an occasional candidate did not know the difference between gastric ulcer and trophic ulcer. Some believed that all multibacillary leprosy leads to sterility. Acute and chronic neuritis was said to be differentiated by the number of nerves involved in the body. While these admitedly are rare instances of howlers, such experience should alert the planners that all is not well with the teaching standards.

GUEST LECTURERS

While some states predominently depend upon guest lecturers from medical colleges, most rural centres do not have this facility. This facility should be utilised with descretion and this will relieve the strain on full time staff in the training centres to a considerable extent particularly with reference to clinical subjects and teaching of anatomy, physiology etc. If this is done full time staff of training centres can devote time for teaching field aspects of leprosy. Enhanced remuneration (Rs. 60/- per lecture) sanctioned by the Central Govt. is not made available in most of the states.

STIPENDS

Most states have not utilised the enhanced stipend of Rs.600/- per month for PMWs. This facility which was extended two years ago has still not been brought into a reality. It is gratifying to note that in Maharashtra this facility is extended to trainees from voluntary organization also. An immediate directive should be sent to all the state officials to see that this stipend is made available for all the candidates including those from voluntary organizations.

Govt. of India should provide for payments of stipend to training of students/of refresher as well as orientation course at various LTCs.

Duration of various refresher courses for which stipend should be fixed is for one week for doctors and MMSs, two weeks for PMWs.

...25

(Multipurpose workers: 3 days, Health Supervisors: 1 week, PHC doctors : 3 days).

UTILIZATION OF LTCs IN BETWEEN TRAINING COURSES

There are some centres where a "saturation point" of trained staff has been reached and there is a gap between conduction of regular training courses. Such centres should be used:

1. For conducting refresher courses for medical and paramedical personnel under NLEP.

2. For orientation training in Leprosy to the general duty Doctors and health personnel and para-professional staff of other disciplines and even general practitioners in the area.

It is distressing to see that in some instances the gap between training courses may be in terms of years. LTC at Barabanky, UP was idle during the gap of two years in 1983 to 1985. There has been no training courses since 1982 in Tirupati, AP the only "up graded" centre visited manned with three MOs. Rajahmundry centre in AP has had no programme since 1979. While some officers in such centres are prepared to conduct refresher courses, the decision regarding this is not often made at the higher level, presumably because it involves travelling and daily allowances. Serious consideration of the wastage of manpower and other inputs owing to this phenomenon at the state level is called for.

OTHER INFRASTRUCTURAL FACILITIES

The following basic necessities of LTCs were found to be inadequate in most institutions:-

Vehicles, teaching space, library, hostel accommodation, audio-visual aids, health education material etc.

Most of these facilities are already on principle provided to the LTCs but found to be nonfunctional or inadequate.

Voluntary organizations as well as some regional training centres are fairly well equipped with regard to the above facilities

Very few state government centres are upto the mark in this regard. As regards vehicles it should be stressed that those meant for leprosy work are frequently used for some other purposes such as family planning work etc in some states.

Leaky lecture halls with rickety chairs and poor hostel facilities as well as trainees were common complaints from well meaning staff. The fact that library books, UNICEF models and slide projectors were not in active use was evident from the dust that had collected on these material kept safe in cupboards. In several centres lecture halls could not be darkened adequately for projection of slides, though the projectors were stated to have been in constant use. The immense value of such teaching aids to augment lectures were obviously not realised by the trainers who still believed in old style of "teacher-oriented" training. It is imperative that MOs and NMSs in-charge of LTCs are made conversent with the application of modern techniques of teaching including effective usage of audio-visual equipments.

Some centres, however were found to have introduced innovative procedures in communication and these should receive encouragement. In one govt. centre, the MO had even used his personal recording equipment to devise a "slide-tape tutor" to facilitate demonstration in local language.

Inefficiency coupled with collousness of a bureaucratic set up alone seems to be the reason for poor state of affairs and hence it is considered beyond the scope of this assessment assignment to make any "recommendations" in this regard, except to state that unless each one of the aforesaid items is considered with conviction as a vital prerequisite for the functioning of any LTC, ideal training can never be contemplated.

VIDEO EQUIPMENT

It is noticed with great concern that the video equipment recently supplied by the Government to the LTCs have not been used fully for a variety of reasons. While problems related to mechanism of operation can be understood, it is learnt that many medical officers incharge of LTCs do not have an idea of the method of maximising the utility of such an extremely useful audio-visual

..26

equipment. They require to be given guidelines on how to make the best use of such facilities. Cassettes proposed to be supplied shortly by DGHS should be used to the maximum extent. Monthly reporting system on the usage of the equipment through recording of the number of programmes, held and target audience in statistical terms should be evolved and DGHS should insist on submission of such report in a standard proforma. Bombay Leprosy Project has evolved a proforma after years of experience in carrying out video programmes.

TRAINING WORKSHOP FOR TRAINERS

It seems necessary that workshop on regional basis should be arranged with the object of adopting uniform methods of teaching field subjects in a task oriented manner; SIOs concerned should take active interest in such workshops. Background working papers on "learner-oriented" teaching devices, newer examination systems from advanced training and research centers should form the basis of discussions in such workshops.

DIPLOMA IN LEPROSY

In this assessment exercise, more importance has been given to raising up manpower through LTCs at the field level, though the value of highly trained medical staff at the top level holding post-graduate qualifications such as diploma etc cannot be forgotten. Recommendations regarding the need for diploma to be offered by all major universities, in leprosy endemic states have been made by expert bodies appointed previously. However, it is learnt that the few candidates with the post graduate diploma have not been either working in leprosy or they have been transferred. The previous expert bodies have recommended that a subcommittee consisting of a leprologist, a microbiologist, a community health specilist, a surgeon, a pathologist and a dermatologist should meet to draw recommendations to the universities on course content, departmental affiliation, mode of examination and other relevent matters.

..28

TRAINING NEEDS OF LOW-ENDEMIC AREAS

In low endemic areas if MDT is introduced and the responsibility of drug delivery is entrusted to the general health services, the duration of training for the various categories of personnel should be the same as in endemic areas. In the training content, MDT component should be emphasised to a greater degree and the technical knowledge of the persons involved should be brought upto-date.

Mobile training teams consisting of suitable selected trainers from various training centres in the states should be constituted and deputed to low endemic states for imparting training to various categories of personnel, wherever such facilities are nonexistant or inadequate. CL RI has sent such mobile training teams successfully to Lakshadweep island in the past.

A manual for MPWs in low endemic areas should be prepared.

TRAINING OF MULTI-PURPOSE WORKER (PW)

Training of MPWs in leprosy should include theoretical lectures as well as field domonstrations. The object of training them is 1) to make them capable of suspecting cases of Leprosy. 2) inquiring about patient compliance during home visits, finding out complications, if any, and referring to appropriate centres and to practise 3) health education during home visits using leprosy as one of the talking points.

MANAGEMENT TRAINING FOR CENTRAL PROGRAMME OFFICERS

State Leprosy Officers and Central Programme Officers, who have not received formal training in leprosy should first receive a short one week orientation training in leprosy. This will be followed by training course in management for one week. The latter course will be conducted by a faculity member from an institute of management who has been exposed to leprosy programme by the leprosy programme officers. Two state leprosy officers and two senior members of the LTCs will also form part of the teaching faculty for the course in the management techniques.

...30

ADMINISTRATIVE BOTTLENECKS

It has to be appreciated that under an administrative set up in a vast country like ours where health is state subject, any improvement desired at any lower level which includes LTC level can materialise only if the chief of the state programme at the apex position namely SLO has strong administrative powers. As long as the status and cadre of SLOs are different in different states, uniformity in the calibre of LTCs cannot be achieved. Hence it is suggested that SLO is elevated atleast to the rank of the Joint Director of Health Services (eg., Maharashtra) if not Additional Director(eg., A.P.). By strengthening the decision-making posts it is believed that the following areas (to mention just a few) which affect the programme at present may be influenced favourably:- 1) retaining vehicles meant for leprosy work from being diverted to other areas 2) retaining trained and experienced staff in LTCs 3) deputing staff to suitable centres for various types of training including refresher courses, workshops and fellowships 4) deciding firmly on matters involving finances such as travelling and daily allowances etc.

In fact the poor state of LTCs is nothing but a reflection of the poor performance of leprosy programme in its totality in some states (e.g. WB, Bihar) over a number of years, for which bureaucracy alone should be blamed. The independent evaluation report (1986) focusses clearly on many such points relating to administration and the remedial measures already suggested need only to be implemented. It is unrealistic to expect extraordinary improvement to be achieved in the calibre of LTCs unless the decisions in relation to state level management of such centres are firmly taken. In this connection it is recommended that the state of affairs with reference to the following centres (which were visited for assessment) require most immediate attention:- Howrah and Bankura in WB, Rajahmundry in AP, Brambe in Bihar, Sehore in MP, Tirukoilur in TN, Dehradun and Barabanky in UP and Kollegal and Gulbarga in Karnataka.

There is an understandable reason for the poor performance of LTCs in Karnataka which switched over from horizintal to a vertical pattern of work reportedly to introduce of MDT, The state

...31

having been under the influence of an integrated hor
pattern of work (using PMWs etc) for too long a peri
relearning to adjust itself into a vertical structure
reappraisal of the administrative decisions necessary
special reference to strenghening of LTCs should be dc
state level in Karnataka.

MODEL CENTRE

It is believed that under the existing circumstances, it will be advantageous to identify two centres functioning under two diverse types of set up viz one with excellent institutional facilities available and another functioning as best as possible in a non-institutional set up without access to hospital atmosphere. These centres could form as models to demonstrate to the trainers on what can be achieved by way of raising competent manpower especially PMWs, the largest field force on which NLEP is dependent. Among the centre visited during the course of assessment , the following stand out as those working of acting as models:

1) Purulia (TLM), hospital-based centre and
2) Nanded (Govt. of Maharashtra), non-institutional set up.

This suggestion is made because it is felt that any amount of deliberations within the four walls to improve systems cannot be complete unless some practical field situations could act as demonstration devises. The training processes adopted in such centres though they may fall short of the ideal could still be used with advantage for trainers to learn.

CENTRAL LEPROSY TRAINING COUNCIL

It is recommended that a Central Leprosy Training Council should be constituted to function as a direct wing of Leprosy Eradication Commission with full statutory powers to implement without delay all recommendations on LTCs so far made as well as to reinforce further progressive measures as when found necessary thereafter with a view to maintain highest standards of training throughout the country.

* * * * *

HIGHLIGHTS OF RECOMMENDATIONS

1. Leprosy Research and Training Centre managed by Central Government as well as leading voluntary organisations such as TLM, GLRA and GMLF should adopt smaller centres on a regional basis and improve their calibre.

2. Candidates not authorised by state programme officers should not be recruited for training.

3. Priority should be given to see that all Non-Medical Supervisors throughout the country are trained within a time bound period.

4. Junior laboratory technicians' (smear) course should be started in as many centres as possible.

5. Teaching techniques and examination systems should be modified in tune with the practical work which the staff are expected to perform in the field.

6. The deliberation of workshops recently held by the Government of India dealing with practical subjects such as "Reactions", "Criteria for cure, discharge, and certification" and "Laboratory Services" in relation to NLEP should be incorporated in the teaching in replacement of several theoretical aspects found in the curriculum.

7. Workshops on a regional basis should be organised to bring the trainers and tutors together in order to adopt uniform techniques of teaching particularly field related topics in a task oriented manner.

8. Training needs of low endemic areas should be attended to with special reference to multidrug therapy of multi-bacillary types of cases.

9. Essential requisities of LTCs such as vehicles, hostel accomodation, audio visual aids etc. should be made actively functional by overcoming bureaucratic procedures and administrative bottlenecks.

10. A Central Leprosy Training Council should be formed as a direct wing of Leprosy Eradication Commission with full statutory powers to implement without dealy all recommendations on LTCs so far made as well as to reinforce further progressive measures as and when found necessary thereafter with a view to maintain highest standards of training throughout the country.

* * * * * *

A P P E N D I X

QUESTIONNAIRE

STATUS REPORT OF LEPROSY TRAINING CENTRES

GENERAL INFORMATION: Date

1. Centres name, address with phone No.

2. Year of establishment.

   Name of the Officer I/C.....Designation.....

   Are you trained in leprosy Yes / No.

   If yes, specify for .....3 weeks/4 weeks/6 weeks/plus 6 weeks/less than 3 weeks.

   Have you availed WHO fellowship training on Leprosy--- Yes / No.

   Did you participate in 1985 meeting of heads of leprosy training centres held at Chinglepattu ? ... Yes / No.

   If no what was the reason ? .....

3. Name, Qualification, Experience etc of all other technical staff of LTC.

4. The present staff position.

Category	No. sanctioned	No. in position	No. trained.
Medical Officer			
NMS			
PMW/NMA/Lep. Insp.			
Health Educator			
Lab. Tech.			
Physio-Tech.			
Other Technical Staff			

II. PERFORMANCE DATA:

1. Total trained till 31.3.86 since inception of the centre (category-wise)

   Medical Officers

   NMS

   PMW/NMA/Lep. Insp.

   Health Educator

..2

Lab. Technician

- 1 year course

- 6 months course

- 3 months course

Physio-technicians

Other technical stuff

2. If you could not organise all/or any of the courses what was the reason ?

3. What was the monthly rate of stipend received by trainees during the year 85-86 ? For Medical Personnel..... Non-Medical Personnel.....

4. Were there instances when some or any of the trainees did not receive stipend during the year 85-86 ? Yes / No.

   If yes what was the reason ? .....

   .....

5. If the medical and non-medical personnel received monthly stipend of less than Rs. 800 and Rs 620 respectively during the year 1985-86 please specify ?

6. Do you have any system of doing post training inservice evaluation ? Yes / No. If yes, how are you doing it ?

   .....

   .....

7. Do you have the following audio-visual equipments ? Also specify working/not working/also specify numbers .....

Film Projector	Yes / No
Slide Projector	Yes / No
VCR - cum - TV	Yes / No

Visual Equipments and other materials:

Over head Projecter	Yes / No
Epidioscope	Yes / No
Micro-scope	Yes / No
Slides for Projector	Yes / No

Do you have films for display Yes / No.

If yes, name of the films.

8. What is the method of teaching followed at your centre ?

   Lecture/Demonstration/Group discussion/field visits/ lab./other

9. Has your centre developed any innovative method of teaching ? Yes / No. If yes specify.....

...3

Has your centre developed any training material ? Yes/No

If yes specify .....

10. Vehicle: (a) - Do you have vehicle - Yes / No.

(b) - If yes, is it being used only by your centre Yes / No

(c) - If not, are you using the NLEP vehicle of the nearest NLEP/VO when required.

11. Do you have leprosy library ? Yes / No.

If yes what kind of material available - books/journals/ other.

Does your library seating arrangement - Yes / No.

12. Teaching space - Do you have the following :-

Lecture hall - Yes / No A Laboratory - Yes / No

Hostel - Yes / No(What capacity)

Library room - Yes / No Faculty room - Yes/ No

Office for records - Yes / No.

13. What materials are supplied to the training free of cost such as : a) Text book on leprosy, b) Govt. publication/guidelines c) other materials.

III. Your training Schedule planned for the year 1986 (1-4-1986 to 31-3-1987):

Category *	Annual capacity	No.of course	No. of seats/ course	Date of starting a particular course
DLO/ZLO				
MO				
NMS				
PMW				
Health Edu.				
Lab. Tech.				
- 1 Yr Course				
- 6 months "				
- 3 months "				
Physio Tech.				
Stat Asst.				
Other				

1. Are you able to conduct all the planned courses ?
   Yes / No. If not what is the reason ? .....

2. Are you able to cover all the planned number of seats for the training - Yes / No. If not state the reasons
   .....
   .....

3. Did you arrange any guest lecture ? Yes / No. If yes give designation of the people invited, topics allotted and honorarium paid per lecture .....
   .....

4. How many official communications you received from State Leprosy Officers relating to the planning & proper utilisation of the training capacity of your centre ?
   .....

5. Does your training centre has a field area attached to it directly under your control ? Yes / No. If yes specify ..
   How much population it covers ?
   How many cases are on record as on 31-3-1986 in the above area .....
   How many cases are on treatment as on 31-3-1986 .....
   How many cases discharged till 31-3-1986 .....

IV Training material received.

1. Did you receive VCR cum TV set supplied by Govt. of India - Yes / No
   If yes, are you using it for training of worker and health education of patients and public ?
   Is it kept directly under your supervision ? Yes / No.
   If not specify under whose supervision it is kept ?

2. Did you receive following other materials supplied directly or through State Leprosy Officer ?
   - Guidelines for case detection, treatment, discharge & follow-up Yes / No
   - Status report of NLEP X - Yes / No
   - Leprosy specimen case cards - Yes / No
   - Pamphlets : Project your child from Leprosy - Yes/No
     When to suspect leprosy ? - Yes/No
     Guide on leprosy to educate public-Yes/No
   - Video Cassettes (List the topics)

...5

3. Did you receive any other educational material/ from State Leprosy Officer or State Health Bureau etc. - Yes/No.

If yes, please name them:

V. BUDGET

Budget allocated to the Leprosy Training Centre for the year 1985-86 and 1986-87 under different heads:-

Particulars	1985-86	1986-87

VI. REMARKS IF ANY

Name & Signature of the
Reporting Officer

A P P E N D I X

ADDRESSES OF LEPROSY TRAINING CENTRES

Sr No.	ADDRESS	CATEGORY OF TRAINING OFFERED	
	ANDHRA PRADESH		
1.	Govt. Leprosy Training Centre Medical College Campus Dist. Chittoor (AP)	PMW	
2.	Govt Leprosy Clinic and Training Centre Afzalganj, Hyderabad (AP) Pin - 500 012	PMW	
3.	Govt Leprosy Control Project And Training Centre Pogiri Dist. Srikakulam (AP)	PMW	
4.	Govt Leprosy Training Centre Rajahmundry East Godavari District (AP)	PMW	
5.	Leprosy Training Centre Philadelphia Leprosy Hospital Salur, Dist. Srikakulam (AP)	MD MMS PMW	LT MT
6.	Leprosy Training Centre Hanamkonda Dist. Warangal (AP)	PMW	
7.	Leprosy Training Centre Gandhi Memorial Leprosy Foundation Chilakalapalli Dist. Srikakulam (AP)	PMW	
8.	ASSAM		
	Leprosy Training Centre Boko, Dist. Kamrup Assam	PML	
9.	BIHAR		
9.	Leprosy Research & Training Institute Urambe Dist. Ranchi Bihar	PMW	

..2

10. Leprosy Control & Teaching Institute
Rajendra Sevashram
Amayrah Nagar
Mairwa, Dist. Siwa
Bihar — PMW

11. Leprosy Training Centre
Damien Foundation
Dhanbad
Bihar — PMW

GUJARAT

12. Leprosy Training Centre
Vadodara
Gujarat — PMW

13. KARNATAKA

13. Leprosy Training Centre
Kollegal,
Dist. Mysore
Karnataka — PMW

14. Leprosy Training Centre
Gulbarga
Karnataka — PMW

15. Leprosy Training Centre
Contrul Leprosorium
Magdi Road
Bangalore
Karnataka — PMW

16. Govt. Leprosy Training Centre
Hubli Dist.
Dharwad
Karnataka — PMW

17. Swiss Emmus, Leprosy Hospital & Training Centre
Hubli,
Dist. Dharwad
Karnataka — PMW

KERALA

18. Leprosy Training Centre
Nooranadu
Distt. Alleppey
Kerala — PMW

18.	MADHYA PRADESHI		
19.	Regional Leprosy Training & Research Institute Raipur Madhya Pradesh	PMI	
20.	Leprosy Training Centre Sehore M.P.	PMW	
	MAHARASHTRA		
21.	Leprosy Training Centre Sholapur Dist. Solapur Maharashtra	PMW	
22.	Leprosy Training Centre Nagpur Maharashtra	PMW	SMEAR TECH
23.	Leprosy Training Centre Gandhi Memorial Leprosy Foundation P.O. Hindinagar Wardha Maharashtra	MO PMW HS	ST TISTICIANS' COURSE
24.	Leprosy Training Centre Jalgaon Maharashtra	PMW	
25.	Leprosy Training Centre Richardson Leprosy Hospital Miraj, Distt. Sangli Maharashtra	NMS PMW	PT
26.	Leprosy Training Centre Nanded Maharashtra	PMI	
27.	Leprosy Training Centre Pune Maharashtra	MO NMS	PMI
	TAMIL NADU		
28.	Govt. Leprosy Treatment and Study Centre Tirukoilur Dist South Arcot Tamil Nadu	PMW	

29.	Leprosy Training Centre Memorijckx Leprosy Centre Polambakka Dist. Chinglepattu Tamil Nadu	PMW	
30.	Central Leprosy Teaching and Research Institute Chinglepattu Tamil Nadu	MO	LT
		NMS	REC SURG
		PT	DLO/ALO
31	Leprosy Training Centre St. Thomas Hospital & Leprosy Centre Chettupattu Dist North Arcot Tamil Nadu, PIN 606801	PMW	
32	Leprosy Training Centre Schieffelin Leprosy Research Centre Karigiri Dist. North Arcot Tamil Nadu	MO	REC SURG
		PMW	PT
		NMS	LT
		SHOE TECH	
33.	Gramaltes Referral Hospital & Leprosy Centre 5 Gajapathy Street Shenoy Nagar Madras - 600 030	SMEAR TECH	
		HE	
	(class of designation)	SHOE TECH	
34.	ORISSA Regional Leprosy Training & Research Institute Aska, Dist Ganjam Orissa	PMW	NMS
		MO	
35.	Leprosy Training Centre Berhampur Ganjam Orissa	PMW	
	UTTER PRADESH		
36.	Leprosy Training Centre Barabanki U.P.	PMW	
37.	Leprosy Training Centre Varanasi U.P.	PMW	
38.	Leprosy Training Centre Central JALMA Institute for Leprosy Tajganj. AGRA	MO	

39. Leprosy Training Centre
Dehradun (U.P.) — PMW

40. Leprosy Hospital and Training (Leprosy Mission) Centre
Naini
Allahabad, U.P. — PMW, PT

WEST BENGAL

41. Leprosy Training and Research Institute
Gauripur
Bankura (WB) — PMW

42. Leprosy Training Centre
School of Tropical Medicine
Chittaranjan Avenue
Calcutta (WB) — MO, NMS, DLO, ZLS

43. Leprosy Training Centre
Purulia Leprosy Home and Hospital
P.O. Box 9, Purulia
(WB) — PMW, PT

44. Leprosy Training Centre
Ramrajatala
Howrah,
(WB) — PMW

45. Greater Calcutta Leprosy Treatment and Health Education Scheme
35/1/A Old Ballygunge 1st Lane
Calcutta - 700 019 — PMW